Informational Hearing on Mental Health Parity
House Insurance Committee
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Mister Chairman and members of the Committee, my name is Michelle Ponce. I am the Associate Director for the Association of Community Mental Health Centers of Kansas, Inc. The Association represents all 26 licensed Community Mental Health Centers (CMHCs) in Kansas that provide behavioral health services in all 105 counties, 24-hours a day, seven days a week. In Kansas, CMHCs are the local Mental Health Authorities coordinating the delivery of publicly funded community-based mental health services. As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs.

We appreciate the opportunity to appear before the committee today to provide information about mental health parity.

Nearly a quarter of a century ago, Congress passed, and the President signed, what was considered to be the first meaningful mental health parity law. Comments made by U.S. Senator Pete Domenici from New Mexico, one of the most conservative senators in office at that time, were powerful and are as follows:

> "Nobody is at fault because somebody has schizophrenia and acts differently and reason differently. They are just as sick as your neighbor who has cancer. Yet only two percent of all individuals with mental illnesses are covered by insurance which provides benefits equal to the coverage for physical illnesses. . . . Through caps that are irresponsible but save money so insurance companies do it in their own self-interest, only two percent of Americans with mental illness are covered with the same degree of coverage as if they got tuberculosis or cancer instead of manic-depression or schizophrenia. You can walk down any street in urban America and you will find them. It is time to give these people access to care they need, and as you see them in urban America sleeping on grates and other things, you should realize that they probably started out as wonderful teenage children in some beautiful family. And when the cost got prohibitive and behavior uncontrollable, they are abandoned."

More recently, in a landmark ruling, a United States District Judge ruled in *Wit v United Behavioral Health* that the country's largest managed behavioral health care organization illegally denied mental health and substance use coverage based on flawed medical necessity criteria. Further, he found that UBH used internally developed medical necessity guidelines that fell short of accepted standards of care to deny outpatient, intensive outpatient, and residential treatment to beneficiaries. While the case did not directly involve the federal parity law, the court recognized that mental and substance use disorders are chronic illnesses and rejected the insurer's

practice of treating patients only for acute symptoms. This establishes a precedent for plans covered by the federal parity law requiring that they pay for continued treatment for mental and substance use disorders, just as they would for any other chronic illness.

We agree with the decision in *Wit* and believe that treatment decisions should be made by qualified mental health providers and patients and their families, who are in the best position to determine patient needs.

Reflecting this, some of the Principles of Accepted Standards of Care as defined by *Wit* include the following:

- Effective treatment requires treatment of co-occurring mental health and substance use disorders and/or medical conditions in a coordinated manner that considers the interactions of the disorders when determining the appropriate level of care.
- Patients should receive treatment for mental health and substance use disorders at the least intensive and restrictive level of care that is safe and effective.
- Effective treatment of mental health and substance use disorders includes services needed to maintain functioning or prevent deterioration.
- The appropriate duration of treatment for mental health and substance use disorders is based on the individual needs of the patient; there is no specific limit on the duration of such treatment.

According to *America's Mental Health 2018* study, 42 percent of the U.S. population considered cost and poor insurance coverage top barriers for accessing mental health care. In addition, when policies do not use accepted practice standards for utilization review, it results in barriers to treatment for patients and excessive time on the part of providers trying to overcome treatment denials on the part of their patients. Delayed care may cause an individual experiencing a mental health need to become more ill, need more services, and take longer to recover.

CMHCs, in addition to the patients they serve, deserve to know how insurance companies are treating their benefits. To that end, we believe that all health insurance companies should be required to submit a core set of information to the Kansas Insurance Department regarding processes for determining medical necessity criteria, identification and analysis of Non-Quantitative Treatment Limitations (NQTLs), and procedures to ensure compliance by health insurance companies.

CMHCs around the state have had good relationships with several of the large insurance companies in our state for well over a decade. Ultimately, our overarching goal is to connect patients with the right treatment at the right time in the right place, and we want to reduce the number of unintended consequences to the greatest extent possible.

Thank you for the opportunity to appear before the committee today, and I will stand for questions at the appropriate time.